Directions: Fill out this slip to the absolute best of your ability and turn in to the receptionist upon completion.

Name: COVID-19 Self-Screening Questionnaire

Date: / /

1. Do you have: a fever of 100.4°F/38°C or higher, a cough, or difficulty breathing? Ⓨ Ⓝ
2. Have you traveled in the past 14 days to regions affected by COVID-19? Ⓨ Ⓝ
3. Have you been in contact with anyone who a has a confirmed COVID-19 diagnosis? Ⓨ Ⓝ

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